DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

AUG 31 2005

Ms. S. Kimberly Belshé
Secretary of the California Health
and Human Services Agency
1600 Ninth Street
Sacramento, CA 95814

Dear Ms. Belshe:

We are pleased to inform you the California section 1115 Medicaid demonstration, entitled Medi-Cal Hospital/Uninsured Care (Waiver 11-W-00193/9), under the authority of section 1115(a) of the Social Security Act, has been approved for a 5-year period that will begin September 1, 2005, and will extend through August 31, 2010.

The Department of Health and Human Services' approval of the demonstration, including the waivers and the costs not otherwise matchable authority that are described in the enclosed list, are conditioned on the State's acceptance of the Special Terms and Conditions (STCs). The STCs will be effective September 1, 2005, unless otherwise specified. All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in this list, shall apply to the demonstration.

The most notable features of the demonstration are:

- The creation of a Safety Net Care Pool which makes available to the State $766 million in Federal matching dollars per year for 5 years (total of $3,830,000,000) for medical care expenditures for the uninsured and for the expansion of health care coverage to the uninsured. Of this $766 million, the availability of $180 million will be contingent on the State meeting milestones specified in the STCs in each of the 5 years. The first 2 years of contingent Federal funds are tied to goals associated with the expansion of managed care to the Aged, Blind, and Disabled population. The last 3 years of contingent Federal funds are tied to goals for expansion of health care coverage to currently uninsured individuals.

- The State must have (and must demonstrate to the Centers for Medicare & Medicaid Services, as requested) permissible sources for the non-Federal share of payments from the Safety Net Care Pool, which sources can include certified public expenditures (CPEs) from government-operated entities. Sources of non-Federal funding shall not include provider taxes or donations impermissible under section 1903(w), intergovernmental transfers from Safety Net Care Pool providers, or Federal funds received from other Federal programs (unless expressly authorized by Federal statute to be used for matching purposes).

- During the term of the demonstration, the State will not impose a provider tax, fee, or assessment on inpatient hospital services, outpatient hospital services, or physician services, proceeds of which would be used as the non-Federal portion of any title XIX payment.

- Private hospitals and some government-operated hospitals will continue to be subject to the negotiated rate process as under Selective Provider Contracting Program and are subject to the applicable upper payment limit.

- Identified government-operated hospitals will be reimbursed through the Medicaid State plan based on costs of Medicaid services as defined in the STCs. The State is permitted to finance Medicaid payments and disproportionate share hospital payments to these providers using CPEs in accordance with approved methodology.

- Total pool funding is capped annually and includes no growth factor or other "without waiver" waiver savings.

Furthermore, we are requiring the State to develop procedures in order to ensure coordination of the waiver with the requirements of Medicare Part D, including tracking demonstration participants who are eligible for benefits under that program and excluding from the demonstration any payment for covered Part D drugs. Federal funds are not available as of January 1, 2006, for drugs covered by the Medicare Prescription Drug Program for any Part D eligible individual or for any cost sharing for such drugs.

Your project officer is Mr. Gary Jackson. He is available to answer any questions concerning your section 1115 demonstration. Mr. Jackson's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
7500 Security Boulevard
Mailstop S2-01-06
Baltimore, MD 21244-1850
Telephone: (410) 786-1218
Facsimile: (410) 786-8534
E-mail: gary.jackson@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Jackson and to Ms. Linda Minamoto, Associate Regional Administrator for the Division of Medicaid and Children's Health in our San Francisco Regional Office. Ms. Minamoto's contact information is as follows:

Ms. Linda Minamoto
Associate Regional Administrator
75 Hawthorne Street
San Francisco, CA 94105

If you have questions regarding this approval, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

Again, congratulations on the approval of your section 1115 demonstration extension. We look forward to continuing to work with you and your staff.

Sincerely,

Mark B. McClellan, M.D., Ph.D.

Enclosures

WAIVER AND EXPENDITURE AUTHORITIES FOR CALIFORNIA'S MEDI-CAL HOSPITAL/UNINSURED CARE SECTION 1115 WAIVER DEMONSTRATION

Title XIX Waivers

Under the authority of section 1115(a) (1) of the Social Security Act (the Act), the following waivers of provisions of the Act are in effect in order to enable California to carry out the Medi-Cal Hospital/Uninsured Care demonstration:

1. **Overall State Plan Requirements** – section 1902(a)—To the extent that the State would be required to describe in its State plan the payment amount or methodology for the basic payment being made for Selective Provider Contracting Program hospital providers.

2. **Statewideness** - section 1902(a) (1)—To the extent necessary to enable the State to vary the demonstration as needed for different geographical areas of the State.

3. **Single State Agency** - section 1902(a) (5)—To the extent necessary to enable the California Medical Assistance Commission to conduct contract negotiations with health care providers

4. **Amount, Duration, and Scope of Services - s**ection 1902(a) (10) (B)—To the extent necessary to allow the State to offer different services, based on differing managed care arrangements or on the absence of managed care arrangements

5. **Institutional Payment Rate-Setting Process** – section 1902(a)(13)(A)(i) through (iii)—To the extent that the State would be required to set rates for hospitals using a public process.

6. **Freedom of Choice** - section 1902(a)(23)—To the extent necessary to require enrollees to utilize facilities which have contracted with Medi-Cal under the Inpatient Hospital Component (formerly the Selective Provider Contracting Program).

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a) (2) of the Act, demonstration costs for the items identified below (which are not otherwise included as expenditures under section 1903) for the period of this extension, are regarded as expenditures under the State's title XIX Plan.

1. Costs of uncompensated care incurred by identified government operated and other identified hospitals during this demonstration project, for hospital and other medical care services, that are not otherwise paid through regular payments for Medicaid services or payments to take into account the circumstances of disproportionate share hospital payments. Federal funding for such costs is limited to $766 million annually, or a lesser amount depending on whether the State meets Medicaid program redesign milestones set forth in the Special Terms and Conditions.

2. Costs of a Health Care Coverage Initiative during subsequent years of this demonstration project that will expand coverage options for individuals currently uninsured. Federal funding for such costs is at least $180 million annually during years 3, 4, and 5 of the demonstration or a lesser amount. depending on whether the State meets milestones set forth in the Special Terms and Conditions.

3. Costs of payments to take into account the circumstances of public disproportionate share hospitals payments that exceed the applicable hospital-specific payment limits (175 percent of uncompensated costs of furnishing hospital services for Medicaid and uninsured individuals) under section 1923(g) of the Act, to the extent the calculation of uncompensated costs is made without regard to Safety Net Care Pool payments claimed for that hospital.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00193/9**

TITLE: **Medi-Cal Hospital/Uninsured Care Demonstration**

AWARDEE: **California Department of Health Services**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for California's Medi-Cal Hospital/Uninsured Care section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the California Health and Human Services Agency (State) and the Centers for Medicare & Medicaid Services (CMS). This Demonstration is approved for the five-year period, from September 1, 2005 through August 31, 2010. The special terms and conditions set forth below and the list of expenditure authorities are incorporated in their entirety into the letter approving the Demonstration.

The STCs have been arranged into the following subject areas: General Program Requirements; General Reporting Requirements; General Financial Requirements.

II. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statues.** The State agrees that it shall comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, & Policy.** All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the award letter of which these terms and conditions are part, shall apply to the Demonstration.

3. **Changes in Law.** The State will, within the time frame specified in law, come into compliance with any changes in Federal statutes or regulations affecting the Medicaid program that occur after the approval date of this demonstration.

4. **Impact on Demonstration of Changes in Federal Law, Regulation and Policy Statements.** To the extent that a change in Federal law, regulation or policy statement impacts State Medicaid spending on program components included in the Demonstration, CMS shall incorporate such changes into a modified budget neutrality expenditure cap for the Demonstration. The modified budget neutrality expenditure cap would be effective upon implementation of the change in the Federal law. If mandated changes in the Federal law require State legislation, the changes shall take effect on the earlier of the day such State legislation becomes effective, or on the last day of any period such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State shall be required to submit Title XIX State plan amendments for reimbursement methodologies affecting Section 4.19-A of the Medicaid State Plan. If a population covered through the State plan is affected by a change to the Demonstration, a conforming amendment to the State plan may be required.

6. **Changes Subject to the Demonstration Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, reimbursement, cost sharing, evaluation design, Federal financial participation, sources of non-Federal share funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. The state shall not implement changes to these elements without prior approval by CMS. CMS and the State shall develop a comprehensive list within 60 days of the approval of the Demonstration renewal that shall contain all elements of the Demonstration that are subject to the amendment process. Amendments to the Demonstration shall not apply before the effective date.

7. **Demonstration Amendment Process.** Amendment requests must be submitted to CMS for approval no later than 120 days prior to the date of implementation. Amendment requests as specified above shall include the following:

    a) An explanation of the public process used by the State to reach a decision regarding the requested amendment;
    b) A current assessment of the impact the requested amendment shall have on budget neutrality;
    c) An explanation of how the amendment is consistent with the overall principles and objectives of the Demonstration;
    d) A description of how the evaluation design shall be modified to incorporate this amendment request.

8. **Demonstration Phase-In-** The following provisions apply to the phase-in of the demonstration:

    a) The existing SPCP waiver is extended through August 31, 2005.

b) For the 22 governmentally-operated hospitals identified in ***Attachment C***, the State intends to modify the contracts entered into pursuant to the existing SPCP waiver within 120 days following the award of this demonstration, to be effective for services rendered on or after July 1, 2005. During the 120-day period:

- The modified contracts for these 22 governmentally-operated hospitals will be negotiated consistent with the provisions of this demonstration; and

- The State is authorized to continue to make per diem payments pursuant to the provisions of the existing SPCP contracts. These payments shall be adjusted retroactively to the amounts determined under the payment methodology prescribed in this demonstration. These claims will be reprocessed and all federal reporting will be adjusted and the federal government will be repaid any federal funds collected that are not offset by CPE payments.

c) Pursuant to the provisions of the existing SPCP contract, private contract hospitals and public contract hospitals that are not identified in Attachment C will continue to be paid per diem payments. The non-federal share of such payments will be funded with state general fund appropriations.

d) The State is authorized to make final payments in connection with any amounts due to hospitals participating under the existing SPCP waiver, as provided under the terms of that waiver and current contracts with such providers for dates of service through August 31, 2005. All remaining supplemental payments shall only go to private hospitals. The non-federal share of such payments will be funded with state or local appropriations. These funds shall remain with the hospital and shall not be transferred back to any unit of governmental.

e) The State is authorized to make final payments in connection with any amounts due to hospitals under the State's DSH program for State Fiscal Years 2003-04 and 2004-05. Such payments will not be treated as payments under this demonstration for purposes of budget neutrality. With respect to such payments, the State cannot use the current method of funding the non-federal share of such payments in which providers do not retain 100% of the total computable claimed Medicaid expenditure for dates of service beyond June 30, 2005.

9. **Demonstration Phase-Out**- The following provisions apply to the phase-out of the demonstration:

a) The State will submit a plan for phase-out of the demonstration to CMS at least six months prior to initiating phase-out activities and, if desired by the State, the State will submit an extension plan (or an application for renewal of the waiver) on a timely basis to prevent termination of the Coverage Initiative

if the demonstration is extended or renewed by CMS. Nothing herein will be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than six months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval.

b) During the last six months of the demonstration, the enrollment of individuals in the Coverage Initiative who would not be eligible for Medicaid under the current State Plan will not be permitted unless the demonstration is extended by CMS.

10. **Suspension or Termination of Demonstration** After a hearing, CMS may suspend or terminate the demonstration, in whole or in part, at anytime before the date of expiration, whenever it determines that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

    a) The State waives none of its rights to challenge CMS's finding that the State materially failed to comply with the terms and conditions of the demonstration. CMS may withdraw waivers or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest.

    b) If a waiver or expenditure authority is withdrawn, or if the entire demonstration is terminated, CMS will be liable only for normal closeout costs.

    c) The State may suspend or terminate this demonstration, in whole or in part, at any time before the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. If the demonstration is terminated, or if any relevant waivers are suspended by the State, CMS will be liable only for normal closeout costs.

11. **Adequacy of Infrastructure.** The State shall ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing; and reporting on financial and other Demonstration components.

12. **Public Notice and Consultation with Interested Parties.** The State shall comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (1994) when any significant program changes to the Demonstration are proposed by the State.

13. **Federal Funds Participation.** No Federal matching for expenditures for this Demonstration will take effect until the effective date identified in the demonstration approval letter.

14. **Funding and Reimbursement Protocol.** The state shall submit for CMS approval, a document which articulates the procedures and methodologies the State will use to determine those costs eligible for federal matching through the certified public expenditure (CPE), consistent with the terms and conditions set forth below. The reimbursement methodologies for hospitals participating in the Inpatient Hospital Component of this demonstration that are not described in Section 4.19-A of the Medicaid State Plan will be described in this document. This document shall include a description of any use of estimates or adjustment factors that will be used to modify actual cost findings. This document will be completed and approved by CMS prior to the state claiming any federal matching funds associated with certified public expenditures.

III. GENERAL REPORTING REQUIREMENTS

15. **Monthly Calls.** CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to health care delivery, enrollment data for individuals served under the Coverage Initiative, quality of care, access, the benefit package, cost-sharing, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers or State plan amendments the State is considering submitting. CMS shall update the State on any amendments or concept papers under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS (both the Project Officer and the Regional Office) shall jointly develop the agenda for the calls.

16. **Quarterly Reports.** The State shall submit progress reports 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports shall include:

    a) A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, enrollment, quality of care, access, the benefit package and other operational issues.
    b) Action plans for addressing any policy and administrative issues identified.
    c) Enrollment data including the number of persons in the uninsured population served under the waiver. Once the Coverage Initiative begins enrollment on September 1, 2007, separate numbers should be reported for uninsured enrollment in the Initiative.

d) Budget neutrality monitoring tables.
e) Progress on the Medi-Cal Hospital/Uninsured Care implementation plan.
f) Other items as requested.

17. **Annual Report.** The State shall submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. The State shall submit the draft annual report no later than 120 days after the end of each operational year. Within 60 days of receipt of comments from CMS, a final annual report shall be submitted for the demonstration year to CMS. Beginning in Demonstration Year 3, the annual report will include data on the number of individuals covered by the Coverage Initiative.

18. **Accounting Procedure** The State will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame. Within six months of the date of the award of this demonstration, the State will implement appropriate controls approved by CMS to ensure oversight of demonstration claiming and expenditures. Within one year of the date of the award of this demonstration, the State will implement an accounting and reporting system acceptable to CMS.

19. Within 120 days following the end of the demonstration, the State will submit a draft final report to CMS for comments. The State will take into consideration CMS's comments for incorporation into the final report. The final report is due to CMS no later than 120 days after receipt of CMS's comments.

20. Within 180 days of the award of the 1115 demonstration, the State will submit to CMS for approval a draft evaluation plan, with specific requirements, time-lines, cost estimates, and a mechanism for monitoring progress of the waiver.

21. CMS will provide comments on the draft evaluation plan within 60 days of receipt, and the State will submit a final evaluation plan within 60 days of receipt of CMS's comments. The State will implement the evaluation plan, and will submit to CMS a draft of the evaluation report 120 days prior to the expiration of this demonstration. CMS will provide comments within 60 days of receipt of the draft evaluation report. The State will submit the final evaluation report prior to the expiration date of the demonstration.

IV. GENERAL FINANCIAL REQUIREMENTS

Payments for Medicaid-Eligible Patients

22. The State will continue the Selective Provider Contracting Program (SPCP) (as described in Attachment E) as part of the 1115 demonstration, subject to Items 14 and 22 and other applicable Terms and Conditions of this demonstration. This

component of the demonstration is referred to as the "Inpatient Hospital" component.

23. Only those private hospitals that contract with the State under the Inpatient Hospital component are paid in accordance with this Demonstration. Payments to these private hospitals will continue to be determined through negotiations with CMAC, and subject to Item 14 and the inpatient hospital upper payment limit for private hospitals.
    a. Reimbursement to private hospitals shall consist of per diem payments, and may also include supplemental payments previously made to those hospitals, including the payments made under the Graduate Medical Education program and the Emergency Services Supplemental Payment program (also known as the SB 1255 program) and shall not exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations.
    b. Replacement program payments (also known as the SB 855 program) will be satisfied through a new supplemental payment for Medicaid inpatient hospital services provided to Medicaid-eligible individuals not enrolled in managed care, and shall not exceed, in the aggregate, the upper payment limit for private hospitals established under CMS regulations.
    c. The non-Federal share of payments to private hospitals may be funded by transfers from units of local government, at their option, to the State. Any payments funded by intergovernmental transfers shall remain with the hospital and shall not be transferred back to any unit of government.

24. Payments to governmentally-operated hospitals not identified in Attachment C that participate in the Inpatient Hospital component will continue to be determined through negotiations with CMAC or by the state plan. Such contract hospitals may be eligible for supplemental payments and are subject to the applicable inpatient hospital upper payment limit for their provider type. DSH payments will be paid in accordance with Item #30. If the state share of payments to governmentally-operated hospitals is funded through CPEs, those CPEs will be calculated in accordance with the requirements and methodologies under Items 14 and the hospitals will be added to Attachment C via a waiver amendment and their reimbursement will be dictated through the State Plan. Nothing in these terms and conditions, or in the State Plan, shall preclude the State from appropriating State General Funds to the governmentally-operated hospitals for the non-federal share of certified expenditures.

25. During the term of the demonstration, the State will not impose a provider tax, fee or assessment on inpatient hospitals, outpatient or physician services that will be used as the non-Federal portion of any Title XIX payment.

26. Reimbursement to governmentally-operated hospitals identified in Attachment C will be based on allowable Medicaid inpatient hospital costs. The estimate of allowable costs will be derived from the most recently audited Medicare 2552-96

cost report as audited by the fiscal intermediary (FI) for purposes of Medicare reimbursement. Interim and final reconciliation will be based on filed and audited Medicare 2552-96 cost reports respectively. The methodology for computing such costs and the required procedures for claiming federal matching funds will be detailed in the Funding and Reimbursement Protocol referenced in Item 14.

a. The State is authorized to make estimated interim Medicaid inpatient hospital payments to governmentally-operated hospitals identified in Attachment C on the basis of the allowable inpatient hospital costs identified on the hospital's most recently audited CMS 2552-96 cost report subject to appropriate trending and as defined in Item 14.

b. The State will base the interim Medicaid inpatient hospital payments for such hospitals on the most recently audited costs as described above and will perform an interim reconciliation of the estimated interim Medicaid payments based on each hospital's current year Medicare 2552-96 cost report filed to the FI for purposes of Medicare reimbursement.

c. The State will perform a final reconciliation of the estimated interim Medicaid inpatient hospital payments (and any interim reconciliation adjustments) based on that current year's audited Medicare 2552-96 cost report as audited by the FI for purposes of Medicare reimbursement.

d. The State may include a reduction factor to ensure that hospitals will not be overpaid based on prior year estimates.

e. Reconciliation will be made on a date-of-service basis. Adjustments for prior year payments must be properly accounted for on the CMS 64.P.

f. All Medicare 2552-96 cost report information for which Medicaid payments are determined and reconciled are subject to CMS review and must be furnished upon request.

g. By September 30, 2005, the State shall submit the necessary State Plan amendments to reflect that, effective July 1, 2005, reimbursement to governmentally-operated hospitals funded by certified public expenditures for inpatient hospital services will be reimbursed based on Medicaid eligible costs incurred by these facilities in providing health care services to Medi-Cal eligible beneficiaries

27. Total computable expenditures certified as the basis for Federal claiming may be based upon all sources of funds available to government entities that directly operate health care providers. However, the sources of funds utilized shall not include impermissible provider taxes or donations as defined under section 1903(w) of the Social Security Act and prohibited by term and condition #25, or other federal funds. For this purpose, Federal funds do not include patient care

revenue received as payment for services rendered under programs such as Medicare or Medicaid.

28. Payments to hospitals under this demonstration may include Medicaid inpatient and outpatient payments to hospitals identified in Attachment C that meet the eligibility requirements for participation in the Construction/Renovation Reimbursement Program, pursuant to California Welfare and Institutions Code section 14085.5. To the extent that the State continues to make these payments, such payments shall not be funded by CPEs and shall be considered Medicaid revenue that must be offset against uncompensated costs eligible for DSH payments. These supplemental payments are in addition to the Medicaid rates described at term and condition #26 for inpatient Medicaid services, and the non-federal share must be funded by state or local general funds.

29. The State shall not receive FFP for Medicaid and Safety Net Pool payments to governmentally-operated hospitals designated in Attachment C in excess of costs as defined in Item 26 or recognized under Item 28. This does not preclude payments to these hospitals from DSH funds.

DSH Payments

30. By September 30, 2005, the State shall submit the necessary State Plan amendment to reflect that, effective July 1, 2005, the statewide DSH allotments under section 1923(f) of the Social Security Act shall be used as follows:

    a. FFP shall be available for DSH payments made to governmentally-operated hospitals funded by: (1) the State General Fund; or (2) CPEs of the 22 governmentally-operated hospitals identified in ***Attachment C*** (and other governmentally-operated hospitals, as approved by CMS).

    b. DSH payments under this Item 30 may be made up to the amount of uncompensated Medicaid and uninsured costs of hospital services furnished by the subject hospital, including costs associated with non-emergency services rendered to unqualified aliens. CPEs will be determined in accordance with Item 26.

    c. A defined DSH pool available for payments to private hospitals to the extent necessary under sections 1923(b) and (c) of the Social Security Act.

31. In addition to the FFP available for DSH payments authorized under Item 30, and to the extent authorized by Federal statute, payments not to exceed 175 percent of the uncompensated care costs for serving Medicaid and uninsured patients may be made to governmentally-operated hospitals. The non-Federal share of payments above 100 percent of uncompensated care costs may be funded by

intergovernmental transfers from the hospitals, or from units of government with which they are affiliated as defined in Item 27.

a. For demonstration years 1 and 2, the state is granted express authority under section 1115(a)(2) to make DSH payments in excess of the statutory, hospital-specific DSH limits. Specifically, for those hospitals eligible to receive 175% DSH, SNCP payments made to a hospital in lieu of DSH payments will not be offset against the DSH eligible uncompensated care costs for purposes of determining the hospital specific DSH limit. Such payments will be offset prior to making a DSH payment to ensure no duplication of payment.

b. With respect to DSH payments made pursuant to this Item 31, the State and county or hospital district/authority (for non-state governmentally-operated entities) will provide annual assurances that any transfer of funds from a governmentally-operated hospital or related governmental unit or entity will be no greater than the non-Federal portion of the payment funded by the intergovernmental transfer.

c. The State will provide assurances that governmentally-operated hospitals will retain the full amount of the payment resulting from the use of intergovernmental transfers. No portion of the payments funded by federal, county, or State funds made to governmentally-operated hospitals will be returned to any unit of government.

d. Retention of such funds by the governmentally-operated hospitals for use in either the current or subsequent fiscal year is allowable. "Retention", when applicable, is established by demonstrating that the retained earnings account of the hospital, at the end of any year in which it received DSH payments funded by intergovernmental transfers, has increased over the prior year's balance by the amount of any DSH payments received in excess of 100 percent of uncompensated care costs (to the extent that the hospital had earnings during the year of up to the amount of such DSH payments). These retained hospital funds may be commingled with county funds for cash management purposes, provided that such funds are appropriately tracked and only the depositing facility is authorized to expend them.

e. Reporting requirements relating to the 175% DSH payments will be specified within the Funding and Reimbursement Protocol defined in Item 14.

32. The State may add two medical centers operated by the University of California (UCLA and UCSF) as specified in Attachment C to those hospitals that are eligible to receive DSH payments, subject to the DSH payment limits established pursuant to section 1923(g) of the Social Security Act and Item 30. The state will

not make DSH payments above 100% to these hospitals. DSH payments to the other three UC hospitals on Attachment C will continue subject to Item 30 and Item 31.

33. The State may redistribute the federal portion of DSH funds it receives which are based on hospitals' CPEs, provided that the recipient hospital does not return any portion of the funds received to any unit of government. No federal matching funding is available for such redistribution. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable. For purposes of applying the DSH payment limit of section 1923(g) of the Social Security Act, amounts claimed for federal match by each hospital shall be counted as payments to the hospital whose CPE generated the FFP rather than the hospital receiving the distributed funds.

Safety Net Care Pool

34. A Safety Net Care Pool will be established to ensure continued government support for the provision of health care services to uninsured populations. Safety Net Care Pool funds may be used for health care expenditures (medical care costs) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act and that are incurred by the State, or by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services provided to uninsured individuals, as agreed upon by CMS and the State. Safety Net Care Pool funds will also be available for a Coverage Initiative in Demonstration Years 3, 4 and 5.

35. The 22 governmentally-operated hospitals listed in ***Attachment C***, the State, a county, or a city are eligible to receive Safety Net Care Pool funds based upon CPEs. The State may, however, add other governmental entities (and may include providers established under state statutes authorizing hospital authorities, hospital districts, or similar entities) to this list, with prior approval of CMS.

36. The State must have (and must demonstrate to CMS, as requested) permissible sources for the non-federal share of payments from the Safety Net Care Pool, which sources can include CPEs from governmentally-operated entities. Expenditures certified as the basis for federal claiming may be based upon all sources of funds available to governmentally-operated entities. However, these sources of funds shall not include provider taxes or donations that are impermissible under section 1903(w) of the Social Security Act, or other federal funds.

37. The Safety Net Care Pool funds cannot be used for costs associated with the provision of non-emergency care to unqualified aliens. To implement this limitation, 17.79 percent of total provider expenditures or claims for services to uninsured individuals will be treated as expended for non-emergency care to unqualified aliens. Nothing in this item is intended to restrict payments for the

provision of care to unqualified aliens pursuant to section 1923 of the Social Security Act.

38. In the event that the use of CPEs by governmentally-operated hospitals is insufficient to access all funds in the Safety Net Care Pool and fully utilize California's DSH allotment, the State must propose alternate legitimate funding mechanisms. However, CMS must review and approve any such alternate funding prior to its use as the non-federal share of a payment under Title XIX. Such proposed funding will not include funding linked to new provider taxes as stated in term and condition Item 25.

39. Hospital costs paid from the Safety Net Care Pool will be determined in accordance with Items 14 and 26. For non-hospital based services, CMS and the State will agree upon cost-reporting formats and define them in the Reimbursement and Funding Protocol.

40. The State may redistribute Federal matching funds drawn against Safety Net Care Pool claims it receives which are based on providers' CPEs, provided that the recipient provider does not return any portion of the payment received to any unit of government and does not claim the CPEs for any other purpose. No federal matching funding is available for such redistributions. Retention of such funds by the hospitals for use in either the current or subsequent fiscal year is allowable and subject to term and condition Items 31(d).

Medicaid Program Redesign

41. For each of the first two years of the demonstration, the availability of demonstration funding for up to $180 million of Safety Net Care Pool funds will be conditioned on compliance with milestones associated with the Medi-Cal redesign proposal. These milestones are as follows:

    a) <u>Demonstration Year 1 (September 1, 2005 – August 31, 2006)</u>.

        1. $90 million of the Safety Net Care Pool funds will be available if managed care legislation is enacted no later than September 30, 2005, to expand the number of counties in California covered by Medi-Cal Managed Care, and to require the enrollment of Medi-Cal only seniors and persons with disabilities into Medi-Cal Managed Care, consistent with the Governor's Medi-Cal Redesign description date January 20, 2005. An additional $90 million will be available if the State submits a Medicaid State Plan amendment, or submits Medicaid waiver requests associated with managed care expansion, by May 31, 2006.

        2. In the event managed care expansion legislation is enacted after September 30, 2005, but before August 31, 2006, a pro rata portion of the initial $90 million will be available based on the number of months

that elapsed after September 30, 2005, before managed care expansion legislation was enacted.

3. In the event all necessary Medicaid State Plan amendments and Medicaid waiver requests associated with managed care expansion, are submitted after May 31, 2006, but before August 31, 2006, a pro rata portion of the second $90 million will be available based on the number of months that elapsed after May 31, 2006, before the amendments or waiver requests were submitted.

4. If managed care legislation is not enacted during Demonstration Year 1, none of the $180 million of the Safety Net Care Pool funds will be available to the State.

b) Demonstration Year 2 (September 1, 2006 – August 31, 2007).

1. $60 million of the Safety Net Care Pool funds will be available if the State continues and completes submission of all necessary Medicaid State Plan amendments, and Medicaid waiver requests associated with managed care expansion, beginning September 1, 2006, through March 31, 2007.

2. An additional $60 million will be available if the State makes managed care contract and rate submissions between September 1, 2006, and August 31, 2007.

3. A third $60 million will be available if expanded enrollment in managed care begins by January 2007.

4. If expanded enrollment in managed care begins after January 2007, but before August 31, 2007, a pro rata portion of the third $60 million will be available based on the number of months that elapsed after January 31, 2007, before the expanded enrollment begins.

5. If managed care legislation is not enacted in Demonstration Year 1, but is enacted in Demonstration Year 2, all terms applicable to Demonstration Year 1 will apply in Demonstration Year 2 in order for the State to access Demonstration Year 2 Safety Net Care Pool funds, and Demonstration Year 1 funds will not be available to the State.

6. If managed care legislation is not passed by August 31, 2007, Demonstration Year 2 funds will not be available to the State.

42. The $180 million portions of the Safety Net Care Pool for each of the first two demonstration years are considered annual allotments dependent on the State implementing managed care and are not available for use in subsequent

demonstration years (i.e., Demonstration Year 1 funds are not available for use in Demonstration Year 2). Assuming the state achieves the managed care benchmarks in term and condition Item 41 and has access to a portion or all of the $180 million for a given year, the State is permitted to utilize Demonstration Year 1 funds for claims with a date of service in Demonstration Year 1 but that are paid in Demonstration Year 2. The State is also permitted to utilize Demonstration Year 2 funds for claims with a date of service in Demonstration Year 2 but that are paid in Demonstration Year 3.

HealthCare Coverage Initiative

43. The availability of $180 million of Safety Net Care Pool funds in each of Demonstration Years 3, 4 and 5 is limited to use to fund a Healthcare Coverage Initiative (Coverage Initiative or CI) that will expand coverage options for individuals currently uninsured. The Coverage Initiative may rely upon the existing relationships between the uninsured and safety net health care systems, hospitals, and clinics. The State may utilize additional portions of the Safety Net Care Pool funds for this purpose, but no portion of the $180 million amount for each of the three years may be used for any demonstration expense other than the Coverage Initiative. The $180 million portions of the Safety Net Care Pool funds for each of the last three demonstration years are considered annual allotments and are not available for use in subsequent demonstration years, if these funds are not spent during the demonstration years. This does not preclude the State from using Demonstration Years 3, 4 or 5 funds to pay for activities performed or services rendered during Demonstration Years 3, 4 or 5 after the end of the respective demonstration year.

44. The State agrees to meet the following milestones for the Coverage Initiative:

- January 31, 2006 — Submit a concept paper on the Coverage Initiative.
- September 1, 2006 — Submit a waiver amendment on structure, eligibility and benefits for the Coverage Initiative.
- September 1, 2007 — Begin enrollment in the Coverage Initiative.

45. The State and CMS will develop a plan to respond to the implementation of the Medicare Modernization Act (MMA). The plan would be effective upon enforcement of the law, regulation, or policy statement.

By September 30, 2005, the State will develop a tracking and identification methodology for all persons under the demonstration that are eligible for Medicare Part D.

After December 31, 2005, no duplication of coverage of the Part D benefits will be provided under this demonstration.

Attachment A
General Financial Requirements Under Title XIX

1. The State will provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Medi-Cal Hospital/Uninsured Care demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide Federal Financial Participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in ***Attachment B*** (Monitoring Budget Neutrality for Medi-Cal Hospital/Uninsured Care).

2. The following describes the reporting of expenditures subject to the budget neutrality cap:
    (a) In order to track expenditures under this demonstration, California will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual (SMM). All expenditures subject to the budget neutrality cap will be reported on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation or premium payments were made). For monitoring purposes, costs settlements must be recorded on Line 10.b., in lieu of Lines 9 or 10.c. For any other costs settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on Lines 9 and 10.c., as instructed in the SMM. The term, "expenditures subject to the budget neutrality cap," is defined below in item 2c.

    (b) For each Demonstration year, <u>at least four separate Forms</u> CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures subject to the budget neutrality cap (see 2 c). All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter will represent the expenditures subject to the budget neutrality cap as defined in 2.c. below. The waiver names for reporting purposes include the following names and definitions: 1) SNCP , 2) CI, 3)private hospital payments, and 4) Government hospital payments.

    (c) For purposes of this section, the term “expenditures subject to the budget neutrality cap” will include all SNCP expenditures, and all expenditures made by or paid to hospitals for Medicaid payments in providing services to patients in accordance with Attachment B, Item 2. All expenditures that are

subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

(d) Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs will be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

(e) All claims for expenditures subject to the budget neutrality cap (including any cost settlements) must be made within two years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

3. The standard Medicaid funding process will be used during the demonstration. California must estimate reimbursable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of reimbursable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each Federal fiscal year (FFY) on the Form CMS-37.12 for both the Medical Assistance Payments (MAP) and State and Local Administration Costs (ADM). CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS will reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

   Subject to CMS approval of the source(s) of the non-Federal share of funding and in accordance with term and condition Item 26, CMS will provide FFP at the applicable Federal reimbursement rate for the following, subject to the limits described in ***Attachment B***:

   a) Administrative costs, including those associated with the administration of the Medi-Cal Hospital/Uninsured Care demonstration.

   b) Net medical assistance payments/expenditures and prior period adjustments paid in accordance with the approved State Plan.

   c) Net Safety Net Care Pool expenditures during the operation of this demonstration.

4. The State will certify State and local monies used as matching funds for the demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval in accordance with term and condition Item 26 and all applicable Federal requirements for the non-federal share match of expenditures. Upon review of the sources of the non-Federal share of funding and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

5. The CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis, subject to Attachment B and an annual calculation of hospital upper payment limits. However, no later than 6 months after the end of each demonstration year, CMS will calculate an annual expenditure target for the completed year. This amount will be compared with the actual FFP claimed by the State under budget neutrality. If the State exceeds the cumulative target, it must submit a corrective action plan to CMS for approval. The State will subsequently implement the approved program.

6. All costs will be claimed in accordance with OMB Circular A-87

Attachment B

Monitoring Budget Neutrality for the California Medi-Cal Hospital/Uninsured Care Demonstration

1. California will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the demonstration period. The Safety Net Care Pool amount will be capped at $766 million (federal funds) for each year of the demonstration ($3,830 million federal funds for five years). In each year, use of $180 million of the Pool amount is restricted by the provisions of Paragraphs 41 through 44 of the terms and conditions. Unexpended funds from the restricted amount may not be used for purposes other than these provisions and may not be carried over to other years. For the balance of the Pool amount each year, any unexpended portion may be expended for Pool purposes in subsequent demonstration years subject to clause 42.

2. The payments to hospitals for Medicaid expenditures in the Inpatient Hospital Component are subject to the following:
    a. The maximum payments to private hospitals shall be the private hospital federal upper payment limit.
    b. The maximum payments to governmentally-operated hospitals shall be the applicable governmental federal upper payment limit and Items 25, 27 and 28.

3. The Safety Net Care Pool cap and the Inpatient Hospital Component cap for payments are separate limits. Unexpended amounts under either cap cannot be moved between funding pools or between agreements.

Impermissible DSH, Taxes or Donations

The CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of impermissible provider payments, health care related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations. The CMS reserves the right to make adjustments to the budget neutrality cap if any health care related tax that was in effect during the base year, or provider related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

How the Limit will be Applied

The limit calculated above will apply to actual expenditures for demonstration, as reported by the State under Attachment A. If at the end of the demonstration period the budget neutrality provision has been exceeded, the excess Federal funds will be returned to CMS. There will be no new limit placed on the FFP that the State can claim for expenditures for recipients and program categories not listed. If the demonstration is terminated prior to the 5-year period, the budget neutrality test will be based on the time period through the termination date.

Attachment C

Governmentally-operated Hospitals to be Reimbursed on a Certified Public Expenditure Basis

5 State Government-Operated University of California (UC) Hospitals

7. UC Davis Medical Center
8. UC Irvine Medical Center
9. UC San Diego Medical Center
10. UC San Francisco Medical Center
11. UC Los Angeles Medical Center

17 Non-State Government-Operated

5 Los Angeles County (LA Co.) Hospitals

12. LA Co. Harbor/UCLA Medical Center
13. LA Co. Martin Luther King Jr./Drew Medical Center
14. LA Co. Olive View Medical Center
15. LA Co. Rancho Los Amigos National Rehabilitation Center
16. LA Co. University of Southern California Medical Center

12 Other Governmentally-Operated Hospitals

1. Alameda County Medical Center
2. Arrowhead Regional Medical Center
3. Contra Costa Regional Medical Center
4. Kern Medical Center
5. Natividad Medical Center
6. Riverside County Regional Medical Center
7. San Francisco General Hospital
8. San Joaquin General Hospital
9. San Mateo County General Hospital
10. Santa Clara Valley Medical Center
11. Tuolumne General Hospital
12. Ventura County Medical Center

Attachment D
Additional Cost Elements for
Governmentally-Operated Hospitals Using Certified Public Expenditure (CPE) Methodology
(For Purposes of Adjusting the CMS 2552-96 Cost Report)

Hospital Cost Element	Medi-Cal Payment			
	Regular Medi-Cal Inpatient CPE	**Safety Net Care Pool UCC**	**DSH UCC**	**Offset DSH Limit**
a) Professional component of provider-based physician costs, including contracted physician costs, which are not part of the inpatient hospital billing. [1]	No	Yes	No	No
(b) Provider component of provider-based physician costs not reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements.	No	No	No	No
(a) Costs of interns and residents in accredited programs.	No	Yes	No	No
(b) Costs of training and supervision provided by teaching physicians not reduced by Medicare reasonable compensation equivalency (RCE) limits, subject to applicable OMB Circular A-87 requirements.	No	No	No	No
(a) Non-physician practitioner costs	No	Yes	No	No
(b) For contracted therapy services, these costs will not be subject to Publication 15-1, Section 1400, limitations (but will be subject to applicable OMB Circular A-87 requirements.)	No	No	No	No
Non-hospital-based clinics that are under the hospital's license and are classified in the Cost Report as "Non-reimbursable Clinics"	No	Yes	No	No
Public hospital pensions	No	Yes	No	No
Administrative costs of the hospital's billing activities associated with physician services billed and received by the hospital.	No	Yes	No	No
Patient and community education programs, excluding cost of marketing activities	No	Yes	No	No

Hospital Cost Element	Regular Medi-Cal Inpatient CPE	Safety Net Care Pool UCC	DSH UCC	Offset DSH Limit
Investigational and "off-label" drugs	No	Yes	No	No
Dental services – Inpatient only	Yes	No	Yes	Yes
Telemedicine services	No	No	No	No
(a) Drugs and supplies provided to non-Medi-Cal patients in non-inpatient or non-outpatient settings	No	Yes	No	No
(b) Drugs and supplies provided to non-Medi-Cal patients in inpatient and outpatient settings	No	Yes	Yes	Yes
Costs associated with securing free drugs for indigent persons	No	Yes	No	No
Patient transportation	No	No	No	No
Services contracted to other providers, including services to treat uninsured patients	No	Yes	No	No
The actual cost incurred by the hospital for physicians' private offices, less the fair market value rent paid by the physicians.	No	No	No	No

Attachment E

The Inpatient Hospital Component (formerly called the Selective Provider Contracting Program and operated under section 1915(b)(4) of the Social Security Act) allows the State to selectively contract with hospitals for acute inpatient hospital services (excluding emergency services) and to limit beneficiary freedom of choice to those hospitals that agree to contract with the California Medical Assistance Commission for Medi-Cal. It is jointly administered by the California Department of Health Services and the California Medical Assistance Commission.

This waiver will incorporate the State's descriptions and assurances with respect to Beneficiary Access and Program Monitoring, as described in Chapters II and III of the "Selective Provider Contracting Program Federal Waiver Renewal" document dated September 2001. The State will ensure the Inpatient Hospital Component of this waiver will not substantially impair access to quality inpatient hospital services and will not restrict access to emergency services.